



ST. CHARLES POLICE AND FIRE DEPARTMENTS

ELDERWATCH PROGRAM

| PARTICIPANT | | | | | |
|--|------|----------|-------------------------|----------------|-------|
| Last Name: | | | First Name: | | |
| Date of Birth: | | | Social Security Number: | | |
| Address: | | | Phone: | | |
| Race: | Sex: | Hgt: | Wgt: | Hair Color: | Eyes: |
| Special needs or Consideration: | | | | | |
| MEDICAL INFORMATION | | | | | |
| Doctor's Name: | | | Phone: | | |
| Hospital: | | | | | |
| Chronic Illnesses: | | | | | |
| | | | | | |
| Allergies: | | | | | |
| | | | | | |
| Medication: | | | | | |
| | | | | | |
| Do you have a Living Will? Yes No (Circle one) | | | | | |
| Do you have an official and signed DNR (Do Not Resuscitate) request form at home? Yes No (Circle one) | | | | | |
| Location in home of Living Will and DNR request form: | | | | | |
| DURABLE POWER OF ATTORNEY | | | | | |
| Name: | | | Phone: | | |
| Address: | | | | | |
| Vehicle Information: Make: Model: Year: | | | | | |
| Color: | | License: | | License State: | |
| EMERGENCY INFORMATION/ NEIGHBOR'S INFORMATION | | | | | |
| Name | | | Address: | | |
| Home phone: | | | Work phone: | | |
| Does neighbor have a key to your home? Yes No (Circle one) | | | | | |



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| RELATIVE'S INFORMATION | | | |
|----------------------------------|-------------|--|--|
| Name: | | Relationship: | |
| Address: | City: | | State: |
| Home phone: | Work phone: | | Key to house? yes no |
| Name: | | Relationship: | |
| Address: | City: | | State: |
| Home phone: | Work phone: | | Key to house? yes no |
| SOCIAL WORKER/AGENCY INFORMATION | | | |
| Agency Name: | | Case Worker: | |
| Phone: | | Does agency have a key to your house? Yes No | |
| Funeral Home Request: | | | |

I am voluntarily participating in the ELDERWATCH program. I understand that this is a cooperative program involving the ST. CHARLES POLICE AND FIRE DEPARTMENT. With your participation in this program, the City will be able to better meet your needs and the needs of the community. Your signature will allow us to share this information with other emergency agencies.

Signature: _____ Date: _____

Witness: _____ Date: _____

Please return this form to:

Elderly Service Officer
St Charles Police Department
2 East State Avenue
St Charles IL 60174

THE KANE COUNTY SHERIFF'S DEPARTMENT DOES NOT PARTICIPATE IN THIS PROGRAM